1115 Behavioral Health Waiver Facility Application Form

1	Agency Name: Date:
2	Physical address: (Location of this facility where services are provided)
3	Mailing address:
4	Program Administrator: Phone: E-Mail:
5	Indicate what 1115 Waiver Services the facility will be providing at this location (check all that apply): ☐ 23-Hour Crisis Observation and Stabilization (COS) ☐ Adult Mental Health Residential ☐ Children's Mental Health Residential ☐ Assertive Community Treatment (ACT) Services ☐ Community Recovery Support Services (CRSS) ☐ Crisis Residential and Stabilization Services (CSS) ☐ Home-Based Family Treatment Services ☐ Intensive Case Management Services (ICM) ☐ Intensive Outpatient 2.1 ☐ Mobile Outreach and Crisis Response Services (MOCR ☐ Partial Hospitalization Program ☐ Peer-Based Crisis Services ☐ Therapeutic Treatment Home Services ☐ Treatment Plan Development/Review
6	What is the target date to begin services at this location: Note: Medicaid enrollment after Department approval requires up to four weeks when processing new applications and backdating enrollment files is prohibited.
7	Would Medicaid be billed for eligible recipients who receive services at this facility location? ☐ Yes ☐ No
8	Choose the National Accreditation Agency that will accredit the location & services: ☐ CARF ☐ Joint Commission ☐ COA ☐ Alternative Accreditation ☐ Unknown
9	I understand that for this location, our agency must collect and report the statistics, service data, and other information requested by the department: ☐ Yes ☐ No

Certification Statement:
I certify that the responses in this request and the information in the attached documents are accurate, complete, and current. I understand the information may be verified by Division of Behavioral Health (Division) staff upon on-site evaluations. I understand the Division has the authority and discretion to grant this approval in the absence of an updated Community Action Plan if it will enhance the continuum of services for the service area.

Name (print): Signature:

(Administrator or Authorized Person)

Date: